Recovery Kernel

DISCONTINUANCE PROTOCOL: OPIOIDS

Die onttrekkingssyndroom is nie wat mense doodmaak nie. Wat daarna kom, dis wat dit doen.

This gids is gebou rondom 'n onderskeiding wat eers moet kom, want dit verkeerd doen is wat lewens kos: opioïdonttrekking self sal, in die meeste gevalle, nie doodmaak nie. Dit is een van die fisies misgerigste ervarings in hierdie hele reeks, maar dit is selde dodelik op sy eie. Wat doodmaak is wat gebeur daarna — 'n terugkeer na 'n vorige dosis deur 'n liggaam wat die toleransie verloor het wat dit gehad het toe daardie dosis normaal gevoel het. Daardie enkele feit herorganiseer byna alles anders in hierdie gids, en dit is waarom medikasie-geassisteerde behandeling (MAT) in die middel sit van rather than at the margins.

Section 0 — Immediate Safety: Read This First

MEDICAL EMERGENCY

Die hoogste-risiko oomblik in opioïdrehabilitasie is nie die onttrekkingssyndroom nie. Dit is terugval na 'n tydperk van abstinensie. 'n Persoon wat ophou gebruik en later terugkeer na hul vorige dosis, doseer met die toleransie van iemand wat nooit opioïede geneem het nie, terwyl hulle die effek verwag van iemand wat gereeld gebruik het. Dit is die enigste mees algemene meganisme van opioïdoordosissterfte, en dit geld met nog groter krag nou dat die illegetiese aanbod wyd besoedel is met fentanyl — sien Afdeling 6.

Call 112 immediately, and use Naloxone if available, for:

- Slow, shallow, or stopped breathing
- Blou of griewe lippe of vingertoppe
- Unresponsive or unable to wake
- Gurgling or choking sounds during breathing

⚠ WAARSKEUWING

Naloxone (Narcan) reverses opioid overdose and is available without a prescription at most pharmacies in the US, often free through harm reduction organisations. Having it accessible — for yourself or anyone in your household with any opioid use history, past or present — is not a sign of expecting failure. It is exactly the same category of precaution as a fire extinguisher: something you hope to never need and keep anyway.

🛡 SANCTUARY

Die fisiese simptome van opioïdwiktrekking self — beskryf in Afdeling 2 — is ernstig en werklik ellendig, maar vir die meeste mense sonder ander ernstige gesondheidskondisies, is hulle nie onafhanklik lewensbedreigend nie. Mediese toesig tydens wyktrekking bestaan hoofsaaklik om die lyding genoeg te verminder sodat 'n persoon nie terugval in die gevaar beskryf hierbo nie, nie omdat die wyktrekking self tipies noodintervensie vereis nie. Om te weet wat hierdie onderskeid is maak die proses nie makliker nie, maar dit verander waaraan om eintlik bang te wees, en wanneer.

Section 1 — Hoekom Hierdie Gids Op MAT Fokus

Medication-assisted treatment — buprenorphine, methadone, or naltrexone — is, by an extensive evidence base, the single most effective intervention available for opioid use disorder. This guide states that directly and without the hedging some recovery material still applies to it: MAT is not a lesser form of recovery, a crutch, or 'still being addicted to something.' It is a life-saving medical intervention with mortality reduction data behind it that few other addiction treatments can match. Recovery work that runs alongside MAT — the biological, environmental, and identity work in Sections 8 and 9 — is additive to it, not an alternatief daaraan.

DIE CENTURION

As fin jy van 'n program of persoon vertel word dat MAT beteken jy 'is nie regtig skoon nie', daardie raamwerk word nie deur die bewyse ondersteun en dit kos lewens. Die maatstaf wat saak maak is oorlewing en funksionering, nie watter spesifieke molekules teenwoordig of nie in 'n persoon se stelsel is nie.

Section 2 — Die Ontwenning Tydlyn

Timeline	What's happening?	What to Expect	What to Do
Ure oore 6–24 (begin, verander volgens die opioïeduur van die bloed).	Opioid receptor occupancy dropping; die stelsel het vertrek sonder sy verwagte invoer.	Nervousness, spierspanning, sweeting, yawnings, snotty nose, vroeë onrust	MAT initiation, if pursued, often begins in this window — buprenorphine specifically requires the person to be in mild-to-moderate withdrawal already before the first dose to avoid precipitating worse withdrawal.
Days 1-3 (peak	Full withdrawal	Nausea, vomiting,	Mediese toesig of

Timeline	What's happening?	What to Expect	What to Do
physical symptoms)	syndrome active; this is the hardest physical stretch	diarrhoea, abdominal cramping, dilated pupils, chills alternating with sweating, severe muscle and bone aches, insomnia	MAT verminder hierdie ernsheid skerp. Dit is ook die hoogste-risiko venster vir iemand wat besluit dat die lyding nie oorleefbaar is nie en terugkeer na gebruik met 'n nou-gevaarlike dosis — sien Afdeling 0.
Days 3-10 (post-acute physical resolution, psychological symptoms peaking)	Physical withdrawal resolving; endorphin and dopamine systems at their lowest point	Deep depression, inability to feel pleasure, raw emotions, ongoing insomnia, persistent cravings, some physical symptoms still hanging around.	Begin full supplement stack (Section 9). Exercise as soon as you are physically able, even a short walk. Sleep management is one of the strongest predictors for avoiding an early relapse— prioritise it directly.
Weeks 1-4	Endorphin en dopamien stelsels herstel stadig; opioïdereseptore begin opregulere	Gradual improvement with real variability day to day; PAWS episodes likely; emotional volatility; episodic but powerful cravings	The full protocol is running. Community connection matters more than it may feel like it should — isolation is one of the strongest relapse predictors in this specific recovery.
Maande 1-6	Significant receptor upregulation; dopamine and endorphin systems actively rebuilding; opioid-induced hyperalgesia	Progressive real improvement; genuine moments of natural pleasure returning; pain sensitivity normalising	Dit is waar die werk volhoubaar word eerder as suiwre oorlewing. Identiteitswerk (Afdeling 9) word hier gepas, nie

Timeline	What's happening?	What to Expect	What to Do
	(amplified pain sensitivity from the opioids themselves) resolving		voor nie.
Maande 6–18+	Mu-opioid receptor density has substantially recovered; the endorphin system is once again producing natural comfort and social bonding.	Natural enjoyment and connection accessible without chemical support; PAWS episodes rare; cravings contextual rather than constant	Full endorphin system recovery for most people by 12–18 months of sustained recovery, whether that recovery includes MAT or not.

Section 3 — Hoe lank voordat die brein regtig normaal is

Full mu-opioid receptor density recovery, in most people, takes 12-18 months of sustained recovery — a timeline consistent with the other longer-recovery substances in this series. Post-acute withdrawal syndrome (PAWS) specifically can run 18-24 months, and for fentanyl-involved recovery specifically, that window may run longer still, given fentanyl's exceptional receptor-binding potency compared to other opioids.

BEING HEARD

As jy agt maande uit is en nog PAWS-golwe kry – skielike angs, 'n hunkering sonder 'n duidelike aanleiding, 'n plat griewe strek van dae – dit is nie bewys dat die werk nie werk nie. Dit is presies waar die eerlike tydlyn jou plaas. Die eindstreep hier word gemeet oor meer as 'n jaar, en om te weet wat jy vooruit sien moet verander hoe 'n moeilike maand agt voel, nie om die moeilike maand laat verdwyn nie.

Section 4 — Wat jy waarskynlik sal ervaar

- A specific, profound anhedonia during the early weeks—food, music, people you love registering as flat rather than meaningful, because the endorphin and dopamine systems opioids were occupying are at a genuine biological floor.
- Verhoogde pyngevoeligheid (opioïd-geïnduseerde hyperalgesie) — 'n ware, gedokumenteerde verskynsel waar die senuweestelsel tydelik meer sensitief vir pyn word as wat dit was voordat opioïdegebruik begin het, terwyl dit herkalibreer. Dit los oor die tydlyn in Afdeling 2 en Afdeling 3 op, maar dit is desoriënterend terwyl dit plaasvind.

- Sleep is something that's genuinely hard to rebuild, often the single strongest predictor of whether an early relapse happens — worth treating as seriously as any other part of this recovery.
- Cravings that can arrive with no obvious trigger, particularly during PAWS waves — this is neurobiological, not a sign of insufficient commitment.
- 'n Deurge voel van sosiale ontkoppling of eensaamheid by G-allel OPRM1 draers spesifiek (Afdeling 5) — dieselfde reseptor wat opioïdreward medieer, medieer ook endorfiën-gebaseerde sosiale binding, so sy uitputting kan voel soos isolasie self, nie net dwelmverlangen nie.

Section 5 — Genetic Cross-Reference

Gene	Wat dit regeer	Opioid Recovery Relevance
OPRM1 (A118G)	Mu-opioid receptor structure — die primêre reseptor waarop alle opioïede optree	The single most important gene in this entire guide. G-allele carriers have reduced receptor binding affinity — meaning they got less pain relief and less reward from standard doses, which is part of what drove escalation. The same reduced binding also means less endorphin-mediated reward from natural sources (exercise, connection, laughter), which is why natural reward architecture can take longer to feel satisfying for this profile. Critically: G-allele carriers show measurably stronger response to Naloxone — this is directly actionable treatment-selection information worth bringing to a prescriber.
CYP2D6	Metabolises codeine, tramadol, and many other opioids to their active or inactive forms	Poor metabolisers get little to no effect from codeine or tramadol, which can drive dose escalation chasing an effect that specific drug will never produce for them. Ultra-rapid metabolisers convert codeine to morphine dangerously fast — a documented mechanism of fatality even at standard prescribed doses. Also affects buprenorphine metabolism directly relevant to MAT dosing.
CYP3A4	CYP3A4	Die dominante farmakokinetiese gen vir die opioïede wat die meeste mense in hierdie herstel navigeer, sluit beide primêre MAT-medikasie in. Beperking van CYP3A4 — van genetika of medikamenteinteraksies (bepaalde

Gene	Wat dit regeer	Opioid Recovery Relevance
		antibiotika, antifungale, selfs grapefruit) — kan gevaarlike akkumulasie van hierdie medikasie veroorsaak. CYP3A4-indusere kan MAT-onttrekking veroorsaak deur die medikasie te vinnig te skoonmaak. Informeer elke voorskrywer van elke medikasie.
ABCB1 (P-glycoprotein)	Bloed-brein barrière dwelmtransportering	Variants beïnvloed hoe baie opioïde die brein kan oorskry vanaf 'n gegewe dosis — sommige variante laat groter sentrale senuwstelsel-penetrasie toe, wat sterker effekte produseer van identiese dosisse en waarskynlik die ontwikkeling van afhanklikheid versnel. Dit beïnvloed ook buprenorfiin- en methadon-sentrale senuwstelselkonsentrasie, relevant vir MAT optimalisering.
DRD2 (Taq1A, A1 allele)	Dopamine DRD2 receptor density	Rougely 30% reduced receptor density in A1 carriers — Reward Deficiency Syndrome. When combined with OPRM1 G-allele, produces a compounded reward-system deficit affecting both the opioid and dopamine reward pathways simultaneously — one of the higher-complexity profiles in this series.
COMT	Dopamine clearance en pynseinigverwerking	Relevant specifically for anyone whose opioid use began with legitimate pain treatment — COMT variants affect baseline pain sensitivity independent of opioid exposure, meaning undertreated pain may still need its own dedicated management track (Section 6) even once the opioid dependence itself is addressed.
MTHFR	Methylation – neurotransmitter synthesis	Basale dopamien en serotonien sintese tekorte wat opioïede moontlik gedeeltelik verseker het. 5-MTHF ondersteuning is fundamenteel, nie opsioneel nie, in hierdie herstel.
GABRA2	GABA-A reseptor alfa-2 subeenheid — basis inhiberende toon	Not die primêre opioïdgen, maar 'n ware bydraende faktor, vir twee redes: dit is dieselfde GABA-argitektuur wat ten grondslag lê vir die algemene opioïd-plus-benzodiazepine of opioïd-plus-alkohol saamgebruikpatroon (elke substansie mik op 'n verskillende

Gene	Wat dit regeer	Opioid Recovery Relevance
		reseptorstelsel vir 'n verwante angs/inhibisieprobleem), en dit dryf die spesifieke gekombineerde profiel wat hieronder uiteengesit word.

How COMT Status Changes What Opioids Actually Feel Like

COMT bepaal hoe vinnig dopamine en streschemikalie skoonmaak, en daardie skoonmaaksnelheid vorm wat opioïede eintlik vir 'n gegewe persoon doen — nie net hoeveel hulle gebruik nie, maar waarom die effek voel asof dit noodsaaklik was in die eerste plek.

COMT Profile	Baseline Before Opioids	Opioids Specifically Provided
Val/Val ('Warrior') — vinnige klaring, laer basisdopaminetoon	Dikwilig om te min gestimuleer aan die rus; aangetrek tot intensiteit en nuwigheid selfs sonder enige substansie betrokke.	Opioids provided a different kind of relief than for other profiles — less 'finally, quiet' and more 'finally, comfortable enough to stop chasing intensity.' This profile is somewhat less common in pure opioid dependence than in stimulant dependence, but when present, recovery needs genuine high-intensity outlets, not just calm-focused work.
Met/Met ('Worrier' / 'Sage') — slow clearance, hoër basisstress-chemiese toon	Dikwels voel angstig of oorgestimuleer in rus; die senuweestelsel neig om warm te loop selfs voordat daar enige substansiegebruik is.	This is die meer algemene opioïd-herstelprofiel. Opioïde se HPA-as onderdrukking (die genetiese tabel in Afdeling 5) beantwoord direk 'n kronies oeraktiewe stresstelsel — die verligting is nie net fisieke gemak nie, dit is die eerste keer dat 'n reeds-heet senuweestelsel kon volledig afskakel. Dit is ook die profiel waar die HPA-as terugslag wat elders in hierdie gids beskryf word, die hardste raak, aangesien daar meer basislyn stres-chemiese aktiwiteit is om oor te skiet.
Heterozygous (Val/Met)	An intermediate baseline between the two profiles above.	Often a blend — some genuine physical relief-seeking, some stress-system relief-seeking — without either being as extreme as the homozygous profiles.

GABRA2 and die 'Angstige Depressant Patroon'

This is worth naming directly rather than leaving GABRA2 as a minor footnote in the table above. Your Compendium's own Gene-Substance Matrix identifies a specific combined profile — GABRA2 high-risk plus COMT Met/Met — as the 'Anxious Depressant Pattern,' relevant across alcohol, benzodiazepines, and opioids: compromised self-soothing capacity (COMT) stacked on compromised

inhibitory tone (GABRA2), producing the most rapid documented progression to dependence of any combined profile in that matrix.

⚠ WAARSKEUWING

If this combination applies to you, two things are worth knowing plainly. First, it's part of why polysubstance use — opioids plus a benzodiazepine or alcohol — is such a common pattern for this specific profile: the opioid is answering the stress-system and pain-relief side, while the GABA-targeting substance is separately answering the underpowered-brakes side, and neither one fully covers what the other is doing. Second, it means recovery for this profile genuinely needs both systems addressed together — the opioid-focused work in this guide, and the GABA-focused work in the Recovery Kernel's Benzodiazepine or Alcohol guides if either substance was also part of the pattern — rather than treating the opioid dependence as the whole picture.

Phenotyping Without Test Results

- Opioids gave you pain relief nothing else could, even at doses others found sufficient? → Possible OPRM1 G-allele or ABCB1 variant. CYP2D6 testing is worth prioritising.
- Het opioïede maak jou laat voel normaal, verbind en gemaklik op 'n manier wat niks anders bereik het nie? → Sterk OPRM1 betrokkenheid en 'n waarskynlike endorfiensisteemtekort. Sosiale binding werk (Afdeling 9) is sentraal, nie aanvullend nie, vir jou herstel.
- Het u gebruik begin met legitieme pynbehandeling? → COMT pyngevoeligheidsvariante kan van belang wees. Onvoldoende behandelde pyn vereis sy eie parallelle behandelingsspoor — sien Afdeling 6.
- Is 'n basisvlak leegheid of anhedonie jou volgehoue ervaring, onafhanklik van opioïedgebruik? → Waarskynlik DRD2 tekort gecombineer met MTHFR betrokke. Dopamienondersteuning is hoë prioriteit.

Section 6 — Special Populations

Situation	What Makes It Different
Chronic pain as the entry point	For a significant portion of people in opioid recovery, genuine chronic pain was the original and remains a real, ongoing condition. Recognizing the genetic vulnerability that drove dependence does not mean the pain itself was never real, and it does not disappear when the opioid does. This population needs a pain management track running parallel to, not replaced by, the recovery track — physical therapy, non-opioid pain management, and in some cases buprenorphine specifically prescribed for pain (a legitimate, distinct use case from its role in MAT for dependence) indefinitely alongside recovery work. Unmanaged pain is one of the most predictable pathways back to opioid use of anything in this guide.
Fentanyl-	The current illicit opioid and, increasingly, illicit stimulant and

Situation	What Makes It Different
gekontamineerde voorsiening	counterfeit pill supply is widely contaminated with fentanyl, which is dramatically more potent than heroin or prescription opioids by weight. Someone with tolerance built on heroin or pills has no reliable protection against a fentanyl-contaminated batch — the potency differential can be fatal at a dose that would have been unremarkable with the substance they believed they were using. Fentanyl test strips (available through most harm reduction organisations) and naloxone access are not optional precautions for anyone with any current opioid use — they are baseline safety equipment, the same category as Section 0's fire-extinguisher framing.
Intravenous/injection route specifically	Carries the additional risks documented in the Recovery Kernel's Ears, Eyes, and Teeth guide — injection-site infection, endocarditis, hepatitis C and B, and HIV. Baseline testing for bloodborne infections is appropriate recovery-phase medical care, not an accusation — and modern hepatitis C treatment is curative in the large majority of cases, regardless of how long the infection has been present.

Die Vervanging- en Afbou-landskap

Vir enigiemand wat spesifiek 'n voorskrifopioïed afbou, verander die substansie self hoe die afbou eintlik lyk. Dit is 'n landskapoorbliik, nie 'n individuele doseringsrooster nie – die presiese syfers vereis 'n arts wat die spesifieke pasiënt, huidige dosis en duur ken. Wat volg is die raamwerk wat waardevol is om in daardie gesprek te bring.

Stoffie	What makes tapering complex?	Die Algemene Benadering
Fentanyl (patch of illicit)	Ekstreme potensie beteken dat selfs klein persentasieverminderinge groot absolute veranderinge verteenwoordig; die transdermale pleistervorm voeg absorpsievariabiliteit by (hitte, veltoestand en pleisterplasing beïnvloed alles aflewering) bo-op die farmakologie self.	Patch tapers meestal na die volgende laagste plakkingssterkte op 'n verlengde interval (gewoonlik elke 2-4 weke, wat dieselfde persentasiegebaseerde beginsel volg wat deur hierdie biblioteek gebruik word), soms met 'n orale brug vir die gaping tussen plakkingssterktes. Ilisiet fentanyl afbou word selde as 'n direkte plakkering-na-plakkering vermindering gedoen — dit vereis gewoonlik eers omskep na 'n meetbare, voorskryfbare vorm (sien MAT, Afdeling 8).
Oxycodone ER (OxyContin) en ander langwerkende orale opioïede	Die verlengde vrystelingsmeganisme beteken dat 'n dosisvermindering beide die piekwerking en die duur van dekking verander – 'n snit wat	Gradual reduction in the extended-release dose, commonly 10-25% every 1-4 weeks depending on duration of use and severity, sometimes with a short-acting

Stoffie	What makes tapering complex?	Die Algemene Benadering
	op papier klein lyk, kan 'n dekkinggat veroorsaak wat baie groter voel.	formulation available for breakthrough symptoms during the transition — a decision for the prescribing physician, not a self-directed addition.
Hydromorphone (Dilaudid)	A kort halflulle en hoë potensie teenoor morfine beteken dat die onttrekkingsbegin vinniger en meer geonsentreerd is as met langerwerkende opioïede, soortgelyk in vorm aan die kort-halflulle probleem gedokumenteer vir venlafaxine in die SSRI/SNRI gids.	Dikwels word dit omgeskakel (geroteer) na 'n langterwerkende opioïed eerste spesifiek om die afbou self meer hanteerbaar te maak, eerder as om die kortwerkende vorm direk af te bou — hierdie omskepsel is 'n regte kliniese tegniek, nie 'n omseiling nie, en moet deur die arts bestuur word gegewe die potensiële wiskunde wat betrokke is.
Tapentadol (Nucynta)	A genuinely different mechanism from the others in this table — dual action as both a mu-opioid agonist and a norepinephrine reuptake inhibitor. This second mechanism means some people tolerate it poorly for reasons that have nothing to do with opioid receptor sensitivity: added norepinephrine activity can produce anxiety, jitteriness, or an elevated heart rate, particularly in anyone already running a high-arousal baseline (the COMT Met/Met profile in Section 5's table is worth considering here specifically).	Asaltadol was not well tolerated, that's genuinely useful information for a prescriber — it may point toward the dual mechanism rather than opioid dosing itself as the source of the problem, and toward a different medication choice entirely rather than just a different dose of the same one.

Pharma's Opioid-Sparing Substitute: Gabapentin en Pregabalin

A common current prescribing pattern deserves the same direct treatment this library already gives it elsewhere: gabapentin and pregabalin are frequently offered specifically to avoid prescribing an opioid, or to support an opioid taper by covering some of the nerve-pain component. This can be a legitimate, useful tool. It can also become its own unaccountable, indefinite prescription if nobody is tracking an exit date.

⚠ WAARSKEUWING

The Recovery Kernel's own material on gabapentinoids applies directly here: these are increasingly recognised as carrying real dependence and withdrawal risk of their own,

including seizure risk at high doses discontinued abruptly, despite historically being prescribed as though they were risk-free. If gabapentin or pregabalin was offered as an opioid alternative, the same accountability questions from this library's Section on substitute medications apply: what is the stated exit date or review point, is this a time-limited bridge or open-ended maintenance, and what would tapering this specific medication look like if it needs to end. A medication that avoided one dependence Risk is not automatically free of dependence risk itself.

Addressing die Onderliggende Oorsaak, Nie Net die Afneem nie

Vir die betekenisvolle bevolking in Afdeling 6 wie se opioïedgebruik met ware pyn begin het, is die afbou self noodsaaklik maar onvolledig — volgens die raamwerk van Afdeling 1 en Afdeling 6, is onbeheerde pyn een van die mees voorspelbare paaie terug na opioïedgebruik van enigiets in hierdie hele gids. Om te ontrafel wat die pyn werklik is, en dit direk te behandel, is nie 'n parallel lekker-om-te- hê nie. Dit is 'n vereiste deel om die afbou te laat hou.

- A real pain-source evaluation—imaging, specialist referral, or whatever diagnostic step hasn't yet happened—rather than continuing to treat only the symptom indefinitely.
- Physiotherapy and non-opioid pharmacological pain management, run by a pain specialist alongside the tapering physician.
- Ketamine infusion therapy — 'n regte, gevestigde opsie vir sekere refraktere chroniese pynkondisies (komplek regionaal pynsyndroom, fibromialgie en sommige vorme van neuropatiese pyn), wat as sub-anestetiese infusie in 'n bewaakte kliniese omgewing gegee word, verskillend van die afbouondersteuningsraamwerk wat ketamine elders in hierdie reeks gegee word. Dit is die moeite werd om direk met 'n pynspesialis te bespreek as standaard nie-opioïede opsies nie voldoende was.

SANCTUARY

If nobody has ever actually diagnosed why the pain exists — only ever treated that it exists — that's worth naming to a physician plainly. Tapering the medication that was managing an unidentified problem, without also pursuing what the problem actually is, is exactly the setup this guide is trying to help avoid.

Section 7 — Use Pattern Classification

Level	Pattern	Risiko	Posture
Prescribed, korttermyn, geen eskalasie nie	'n regte voorskrif gebruik soos voorgskik, vir 'n beperkte tydperk	Laag, maar nie nul nie – fisiese afhanklikheid kan begin binne 1–2 weke van gereelde gebruik	'n Beplande afneming met die voorskrywingsarts, eerder as 'n skielike stop, bly steeds die veiliger standaard selfs

Level	Pattern	Risiko	Posture
		selfs sonder misbruik.	op hierdie vlak.
2 — Prescribed, longer-term, or mild escalation	Using it regularly past the initial prescribed time, or slowly bumping up the dosage to keep the same effect	Moderate — fisiese afhanklikheid is waarskynlik gevestig	'n Begeleide afbou is belangrik hier; abrupte stopbing voorsien ernstige terugtrekking, en dit is presies die populasie waar 'n gesprek oor MAT, selfs korttermyn, proaktief werd is om te hê.
3 — Regular non-prescribed or significantly escalated use	Overdosing, taking someone else's meds, or regular illegal use without constant round-the-clock dosing	Hoog	Medical involvement is strongly advised before any attempt to stop. MAT should be a real part of this conversation, not a last resort.
Dependent, daily use including to avoid withdrawal	Dagelijkse of bijna-dagelijkse gebruik, insluitend gebruik specifiek om ontwenningssymptome te voorkomen in plaats van voor effect.	Severe — this is the population Section 8's MAT and detox protocol is written for	Do not attempt unsupervised cessation. Section 0's relapse-overdose warning applies with full force to this population specifically.

Section 8 — Medication-Assisted Treatment and Detox

Medication	Mechanism	Clinical Notes
Buprenorphine (Suboxone, Subutex, Sublocade)	Partial opioid agonist — activate die reseptor genoeg om terugtrekking en hunkering te voorkom, met 'n plafon-effek wat oordosering-risiko beperk vergelyk met volle agoniste.	Dit vereis dat die persoon reeds in milde tot gematigde onttrekkingssyndroom is voordat met die eerste dosis (om voorgestelde onttrekking te vermy). Dit kan in 'n kantoorgebaseerde omgewing deur opgeleide voorsieners voorgeskryf word, wat die toegang aansienlik verbeter vergeleke met methadone se kliniekgebaseerde model.
Methadone	Volledige opioïde agonis, langwerkend – stabiliseer reseptoraktiwiteit sonder die pieke en trogke van kortwerkende opioïede	Usually requires daily dosing at a licensed opioid treatment programme, at least initially. There's strong evidence base, especially for more severe or long-

Medication	Mechanism	Clinical Notes
		term dependence. CYP3A4 status (Section 5) affects the dose.
Naltrexone (orale of verlengde vrystellying Vivitrol)	Opioid receptor antagonist — blokkeer die reseptor heeltemal eerder as om dit te aktiveer, wat geen opioïdieffek produseer nie en die effek van enige opioïdie wat daarop gebruik word blokkeer.	Vereis volledige ontgifting (gewoonlik 7-10 dae opioïdvry) voordat dit begin word, aangesien dit ernstige onttrekkingssymptome sal veroorsaak as opioïde nog in die stelsel aktief is. OPRM1 G-allel draers (Afdeling 5) toon merkbaar sterker reaksie — werklik nuttige, uitvoerbare behandeling-keuse-inligting.

DIE CENTURION

MAT selection is a real clinical decision that benefits directly from the genetic information in Section 5 — bring it to whoever is managing this with you.

Section 9 — Die Herstelprotokol

Tier 1 — Biologiese Grondslag (Vandag 1 en verder)

Support	Role
DLPA (DL-Phenylalanine)	Endorphin system precursor support — start Day 1 if eating.
NAC (600mg twee keer per dag)	Glutamate homeostasis en hunkeringvermindering.
5-MTHF	Foundational methylering en neuro-overdrager sintese ondersteuning.
Magnesium glycinate	General nervous system support and sleep.
Omega-3 (EPA-dominant)	General neurological support during a period of significant system rebuilding.

Tier 2 — Mediese

- MAT per Section 8, as the primary medical intervention, not an adjunct.
- Pain management track (Section 6) running in parallel if chronic pain is present — this is not optional for that population.
- Bloodborne infection testing and treatment if injection use history is present (Section 6).

'n Laag-Koste Praktiese Gereedskap: Tydvergrendelde Dispensering

Worth naming directly because it's inexpensive, genuinely useful, and not often mentioned in recovery material: time-locked medication safes exist specifically for situations like a taper, where the goal is controlled, scheduled access rather than

either full self-access or no access at all. A trusted person — a partner, family member, or other overseer — loads the doses according to the taper schedule set with the prescribing physician, and the device physically will not open until the scheduled time, regardless of how the person taking the medication feels in the moment. This directly addresses the same access-and-friction mechanism named elsewhere in this library's discontinuation series: removing the ability to act on an impulsive urge for an early or extra dose is itself a real, physical form of support, not just a symbolic one.

⚠ WAARSKEUWING

Standard warnings apply, and they matter: this is a support tool, not a substitute for the medical taper plan itself, and not a substitute for MAT or physician supervision where those are indicated. It requires a genuinely trustworthy, consistently available overseer — the tool doesn't work if the person controlling it isn't reliable, and it can become a source of conflict or resentment if introduced without an honest conversation about why. It does not prevent someone from obtaining medication or substances outside the device entirely, so it addresses one specific risk (impulsive early redosing of the tapering medication) rather than die hele prentjie. Die meeste modelle het 'n soort noodoorrideerder — weet wat dit is en wie dit beheer voordat jy op die toestel vertrou. En dit mag nooit die enigste veiligheidsmaatrek wees vir enige in die hoër-risiko klassifikasies in Afdeling 7 nie — dis 'n praktiese ondersteuning langs mediese sorg, nie 'n vervanging daarvoor nie.

On Illicit-Origin Substances: Hoekom 'Net Deurkom Na Dat Die Afneming Klaar Is' Sy Eie Gevaar Is

This deserves direct, serious treatment rather than a passing mention, because the risk is categorically different from anything else in this guide. A medication from a licensed pharmacy has a documented chain of custody — manufactured under regulated conditions, verified in dose and composition, traceable at every step from production to the bottle in hand. A substance obtained outside that system has none of this. No paperwork, no certification of origin, no verification of what's actually in it, no way to know what it passed through or was combined with before reaching the person taking it. This is not a a moral judgement about the choice to seek it—it's a physical fact about the object itself that matters regardless of why someone sought it.

MEDICAL EMERGENCY

This is not abstract risk. Per Section 6, the current illicit opioid supply — and increasingly the illicit and counterfeit pill supply generally — is widely contaminated with fentanyl, which is potent enough by weight that a fatal dose can be present without any visible, tastable, or detectable difference from an uncontaminated version. Someone bridging a gap during a taper, or seeking relief from withdrawal symptoms outside medical channels, by using whatever is available on the street or from an unverified source, is not making the same category of decision as continuing a supervised medication. It is a decision made with zero information about what is

actually being taken. Fentanyl test strips and Naloxone (Section 0, Section 6) reduce but do not eliminate this risk — the only way to fully avoid it is to not use an unverified source at all, which is exactly why the medical and MAT pathways in Section 8 exist as the recommended route through a taper, difficult as that route can be to access.

Tier 3 — Nervous System and Endorphin Architecture (Maande 1-12, die sentrale fase)

- Daglike kragtige oefening – die primêre endorfiendrywer beskikbaar sonder medikasie, en die enigste mees konsekwente aanbeveling oor elke gids in hierdie reeks.
- Genuine community and connection — not incidental, but structural, given how directly the opioid receptor system mediates social bonding reward (Section 5).
- Kou blootstelling, gelag en musiek – elkeen met werklike, hoewel kleiner, endorfin-aktiverende effekte wat dit werd is om saam te stapel.

SANCTUARY

Die endorfiën-argitektuur bou herop deur konsekwente daaglikse oefening oor maande, nie deur episodiese poging nie. Dit is nie 'n kritiek op enigiemand wat sukkel om dit vol te hou nie — dit is die eerlike vorm van wat hierdie herstel eintlik vereis, ooreenkomstig met die eierlike tydlyn in Afdeling 3.

Emerging Addition: Oxytocin and the HPA-Axis Reset

This section exists because your own Main Book dedicates a full chapter to it, and it deserves an honest, correctly-caveated place here rather than being left out. The mechanism it addresses is real and already named elsewhere in this guide: opioids suppress the HPA axis for as long as they're used, and when they're removed, that suppressed system doesn't return gently to baseline — it rebounds, often dramatically overshooting it. Cortisol floods, the amygdala runs hot, and the nervous system reports an existential emergency with no external cause. This is the physiological reason opioid withdrawal can feel like dying even when it isn't medically dangerous (Section 0) — the felt sense is an accurate report from a genuinely overdriven stress system, not an irrational reaction.

⚠ WAARSKEUWING

Oxytocin is a direct antagonist of the cortisol-releasing cascade — it inhibits the HPA axis, functioning as a real off-switch for the alarm system opioids were keeping quiet. Your own source material is explicit and worth repeating with the same honesty: this protocol is experimental, not FDA-approved for addiction treatment, and used currently by only a small number of forward-thinking clinics and informed individuals working at the edge of recovery science. It belongs in this guide as a documented, real mechanism worth knowing exists — not as a self-directed intervention. Anyone considering it should do so with a psychiatrist or adiction medicine physician actively

involved, the same standard this series has held for every other Emerging-tier addition.

Practically speaking, this falls into the same category of addition as the intranasal oxytocin material already documented elsewhere in the Recovery Kernel's discontinuance series for benzodiazepine withdrawal — the mechanism (HPA-axis dampening) is identical, and the appropriate caution remains the same: real, worth a chat with a specialist, but not yet a standard-of-care tool.

Section 10 — Emergency Recognition, Restated

MEDICAL EMERGENCY

SKEL 112 EN GEBRUIK VAN NALOXONE AS BESKIKBAAR VIR: stadig, oppervlakkige of gestop asemhaling — blou of grijs lippe of vingertoppe — nie reageer nie — gurgelende of verstikkingsgeluide. Dit geld met besonder sterkte na enige tydperk van verminderde gebruik of abstinensie, gegewe die verlies-toleransiemechanisme in Afdeling 0, en met fentanyl kontaminasie (Afdeling 6) as 'n bykomende, onvoorspelbare risiko-laag op enige illiese bron opioïedrug.

Section 11 — Full Protocol Cross-Reference Map

Reference	What It Offers
Recovery Kernel Opioid Guide, Section 3	Die volledige MAT en detoks-raamwerk wat hierdie gids se Afdeling 8 opsom.
Recovery Kernel Fentanyl Guide	Contamination-specific detail for Section 6 — testing strips, Naloxone access, and the specific pharmacokinetics of fentanyl versus other opioids.
Recovery Kernel Ears, Eyes, and Teeth Guide, Section 5	Full detail on injection-related infection risk referenced in Section 6.
Compendium Protocol 14 (Pynbestuur)	Die parallelle pynbestuurspad verwys na in Afdeling 6 vir enigiemand wie se opioïdbruik met legitieme pynbehandeling begin het.
Compendium Protocol 05 (Omgewingsherontwerp)	The highest-priority protocol for this specific recovery — cue-triggered craving is the primary relapse mechanism in opioid recovery, more than in most other substances in this series.
Compendium Gene-Substance Matrix, Appendix A	The direct protocol-code mapping behind Section 5's genetics: GABRA2 + COMT Met/Met ('Anxious Depressant Pattern') maps to P06, P09, P10, P21; GABRA2 alone maps to P01, P06, P20; GABRA2 + MTHFR ('Depleted-Impulsive Pattern') maps to P06, P07, P11, P21. Cross-reference this appendix directly if a full genomic panel is available.
Recovery Kernel Main Book, Section 8 (Oxytocin Protocol)	Die volledige bronhoofstuk agter Afdeling 9 se Opkomende Byvoeging – volledige meganismebesonderhede, en dieselfde eksperimentele-

Reference	What It Offers
	gebruik waarskuwings wat in hierdie gids herhaal word.
Compendium Protocol 20, 21, C-28 (Identity Architecture)	Gee dit geskik om te begin rondom Maande 1-6 (Afdeling 2), nie vroeër nie – herbou identiteit los van die gebruikgeskiedenis.
Recovery Kernel Complex Trauma and the Substance Connection	Opioid use disorder begin frequent in conditions of profound adversity; trauma-specific work should not start until biological and MAT stability is established — timing matter here as much as anywhere in this series.

Section 12 — Sluiting

SANCTUARY

Opioid recovery is one of the few areas of addiction medicine with a genuinely strong, well-established evidence base behind its most effective treatment — MAT saves lives, repeatedly, measurably. Using it is not a lesser form of recovery. The endorphin and receptor systems opioids occupied can and do rebuild, on a real timeline, whether or not that recovery includes ongoing medication. What matters most, per Section 0, is surviving the window where tolerance and expectation fall out of sync — everything else in this guide exists to get you safely past that point.

END OF GUIDE — DISCONTINUANCE PROTOCOL: OPIOIDS

Harm Reduction Resource — Not Medical Advice — Not a Substitute for Emergency Care

Crisis Resources: 988 (Suicide & Crisis Lifeline, call or text) | SAMHSA: 1-800-662-4357